PCMH Quality Metrics Subcommittee
Meeting Summary
June 8, 2016

Attendees
Dr. Janice Gomersall, Community Physicians Group
Kristen Schuster, Glacier Medical Associates
Jody Haines, Providence Medical Group
Paula Block, MPCA
Erwin Austria, Blue Cross Blue Shield of Montana
Julia Vannick, KRHC Woodland Clinic
Caroline B, Northern Montana Healthcare Center
Corinne Brainard, Bozeman Health
Lindy Worthington,
Karen Shaw, Great Falls Clinic
Patty Kosednar, Health Technology Services
Lisa Underwood, MPCA
Kathy Myers, MT DPHHS-Chronic Disease Prevention and Health Promotion Bureau
Dorota Carpenedo, DPHHS
Lisa Schmidt, DPHHS
Heather Zimmerman, DPHHS
Carrie Oser, DPHHS
Desa Osterhout, Blue Cross Blue Shield of Montana

CSI Staff
Amanda Roccabruna Eby
Catherine Wright
Christina Goe

The state epidemiologists in attendance reviewed the status of data analysis. Overall the data looks good but they are waiting for corrected data from several clinics. Next they will produce the necessary charts (showing data for each measure compared to national estimates and the Healthy People 2020 target) that are part of the public report.

Next, there was discussion about confusion by several clinics concerning the tobacco and depression metric guidance. Lisa Schmidt explained that as the tobacco guidance is written it is unclear that *non-smokers* are also included in the numerator.
CSI sent an email to clinics that submitted aggregate tobacco data, clarifying the guidance and asking clinics to respond whether their data was pulled according to the following:

The **tobacco denominator** should be the following:

- Total number of patients aged 18 and older who had a visit in the calendar year of 2015

The **tobacco numerator** should be the **sum** of the following two numbers:

1. Total number of patients in the denominator population who were screened for tobacco use at least once within 24 months AND were identified as a tobacco user AND received cessation counseling intervention
2. Total number of patients in the denominator population who were screened for tobacco use at least once within 24 months AND were identified as a non-tobacco user

Thirteen clinics responded that they had not pulled their data that way and would not re-pull data so wanted to be excluded from program analysis for the public report for that measure and that measure would also be excluded from their clinic feedback report.

Heather Zimmerman explained that a similar issue was discovered with the depression metric with confusion regarding whether or not patients who screened negative for depression were to be included in the numerator. Again, CSI sent an email to clinics that submitted aggregate depression data and asked them to clarify how they pulled their data.

The **depression denominator** should be the following:

- Total number of patients aged 12 and older who had a visit in the calendar year of 2015

The **depression numerator** should be the **sum** of the following two numbers:

1. Total number of patients in the denominator population who were screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND screened positive AND a follow-up plan is documented on the date of the positive screen
2. Total number of patients in the denominator population who were screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND screened negative

Based on the clinic responses, only 1 clinic had not pulled their data as explained and opted not to re-pull it. Of the 10 clinics that originally submitted patient-level data, 7 switched to aggregate due to issues with their data pull.

Patty Kosednar explained the version changes and the eCQM QRDA (electronic Clinical Quality Measures – Quality Reporting Document Architecture) specifications. They can be found by visiting https://ecqi.healthit.gov/ , click on EP Measures, then click on eCQMs for 2016 Reporting Period.

Here are the links to each MT PCMH Program measure:

1. Controlling high blood pressure – last year was CMS 165 V3, is now CMS 165 V4:
https://ecqi.healthit.gov/ep/2014-measures-2015-update/controlling-high-blood-pressure

2. Tobacco Use Screening & Cessation – last year was CMS 138 V3, is now CMS 138 V4
https://ecqi.healthit.gov/eh/2014-measures-2015-update/preventive-care-and-screening-tobacco-use-screening-and-cessation

3. Diabetes Hemoglobin A1c Poor Control – last year was CMS 122 V3, is now CMS 122 V4:
https://ecqi.healthit.gov/eh/2014-measures-2015-update/diabetes-hemoglobin-a1c-poorcontrol

4. Screening for Clinical Depression – last year was CMS 2 V4, is now CMS 2 V5:
https://ecqi.healthit.gov/eh/2014-measures-2015-update/preventive-care-and-screening-screening-clinical-depression-and-follow

This eCQMs for 2016 Reporting Period list shows what logic changes were made from last year to this year according to the Measure Name, CMS IC, NQF ID, and Domain. Depending on submission method for PQRS, GPRO or individual provider or other various options, PQRS specifications are different. According to Patty, PQRS is not a good standard to have for the state program specifications since PCMHs use different reporting methods so do not report the same data to PQRS. She further suggested that the eCQM specifications would be a better standard for the state program. EMR vendors are

required to make the logic available for eCQM specifications so this is the closest to consistency the program could get when aspiring for alignment. EMRs are required to make the fields available for the patient-level data in the eCQM QRDA specifications. However, not all clinics necessarily have the access to those fields turned on in their EMRs. Also, the Montana PCMH program is asking for more and different fields than CMS is so manual data extraction is required for the fields that are not made available in the EMR.

Kristen Schuster commented that her EMR will not pull the patient's blood pressure value, A1c value, or date of cessation for tobacco. It would cost $10-15,000 to request custom reports if her clinic did not build them manually. Jody Haines commented that her organization has had to have a greater conversation around resources due to data reporting requirements and tasks have to be approved by committees and then assigned to staff. She has noticed that the number of custom reports being approved by committees has been dwindling. Karen Shaw of Great Falls Clinic commented that they tried many different customizable reports to get the patient-level data, using Meaningful Use and their vendor's reports but they could not put the data together from two EMRs since they had changed mid-year. Patty commented that EMRs are required to be able to provide functionality and if they are ONC certified then they can produce the QRDA reports. Lisa Underwood commented that not every eCW EMR user is on the same version so purchasing custom reports collectively would not necessarily help all the eCW users. BCBS commented that they are working to align all of their required reporting metrics with national standards and will align the required fields for the metrics as well. Patty Kosednar recommended that BCBS and the Montana PCMH program align with the cCQM standards.

ACTION ITEM: Patty will work with Jody Haines, Kristen Schuster, Lisa Underwood, and CSI to research the option of using the CMS quality reporting data architecture format (QRDA) for collecting and submitting data to the Montana PCMH Program. She will initially get information for EPIC and eCW (CHC and non-CHC) users and based on the findings, investigate other vendors. (Those three vendors make up 73% of the Montana PCMH Program participants.)
After this small working group determines what is currently available and achievable for PCMHs on EPIC and eCW they will report back to the Quality Metrics Subcommittee at the July 13th meeting and the subcommittee will discuss and decide how to move forward.